CATT Clinic

Coastal Area Thyroid Treatment Clinic

A Division of College Road Animal Hospital, PLLC

Referral Form

Referring Veterinarian ____
Referring Animal Hospital ____
Hospital Telephone Number ____________________________
Hospital Fax Number __________________________________
Client's Name ____
Client's Address____
Client's Email____
Client Contact Number ________________________________
Cat's Name ______________________ DOB_______ Sex_______ Breed ________
Indoor/Outdoor _________________

Vaccine Due Dates:
FVRCP ________________ Rabies ______________ Feleuk _________________

Patient must have a CBC/Chemistry, SDMA and Urinalysis completed within the past 60 days. Pet must have a T4 level completed no less than 7 days after discontinuing Methimazole/Tapazole

CBC/Chemistry Date __________________________
SDMA Date __________________________________
Urinalysis Date _______________________________
Initial T4 Date ____________________ Result ___________________________
T4 (after discontinuing Methimazole) Date _______________ Result _____________________
* Please submit T4 results from a reference lab, not an in-house test
Thyroid Nodule (if present, size, location) _________________________________
Methimazole Dose (if applicable) ____

Remarkable Exam Findings/Concurrent Disease

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____
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____
____
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Has the pet ever needed sedation for routine procedures (i.e. exam, vaccines)
Yes ( ) No ( )
If yes, please explain. ____
____

Please attach all laboratory results
Fax 910-392-3126